EyeMed
The Eye Care Plan of America℠

Enrollment/Change Form

Please print and complete all sections. See instructions below.

EMPLOYER INFORMATION

Employer Name
CITY OF LINCOLN, NEBRASKA
Group Number
CITY LINCOLNLocation Code
Effective Date

EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

A T C	Sex M F	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth	Social Security Number

Home Street Address	City/State/Zip	Home Phone ( )	Work Phone ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

A T C	Sex M F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number
A T C	Sex M F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
A T C	Sex M F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
A T C	Sex M F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
A T C	Sex M F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
A T C	Sex M F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number

Employee Signature: _____ Date: _____

Instructions

Employer name: Legal name of the employer.
Group Number: Provided by EyeMed or EyeMed representative.
Location code: Optional field for employers to track multiple locations.
Effective date: Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling.
Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.